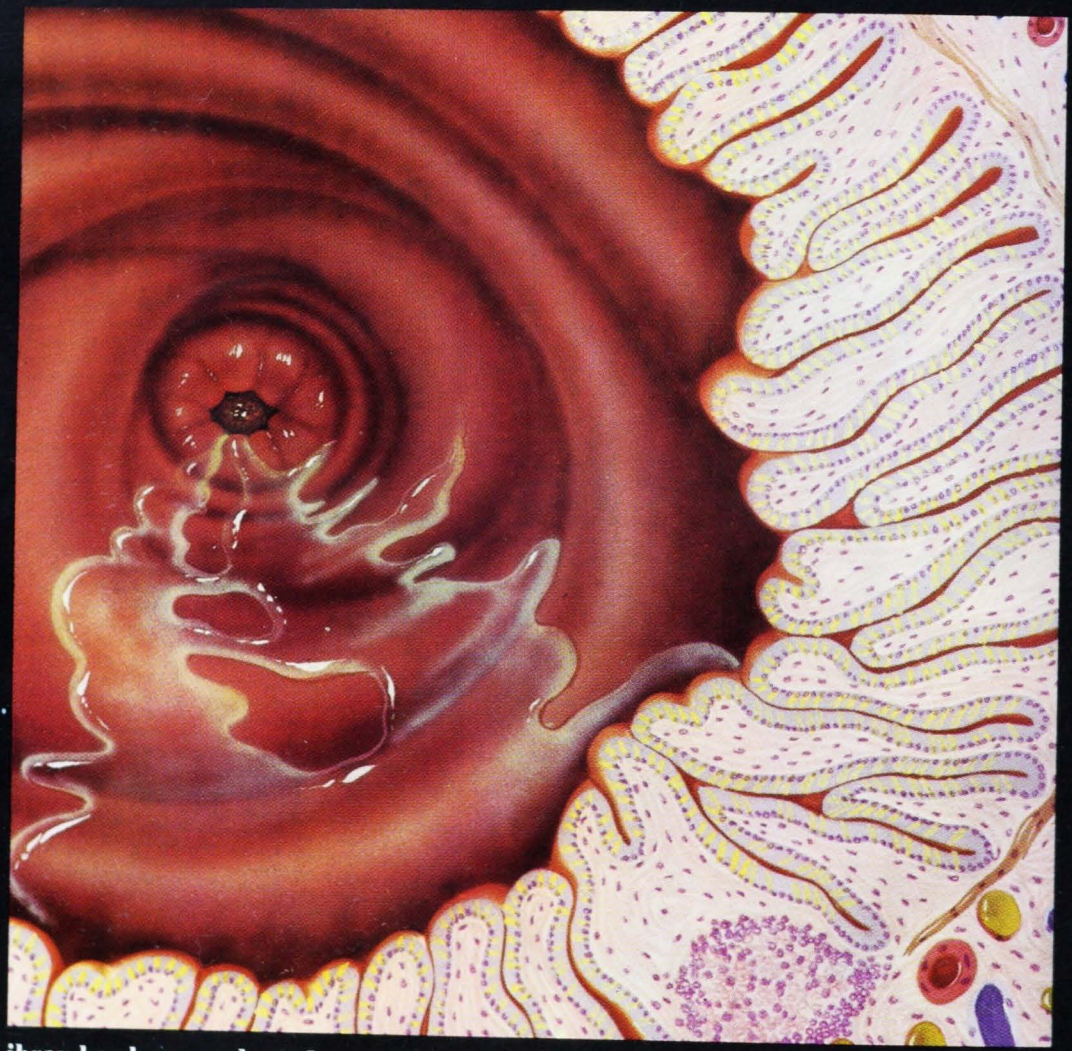
TEXAS OSTEOPATHIC PHYSICIANS

# JOURNAL

December 1976

Presenting Gastrointestinal Complaints

# Pain and bloating with diarrhea and/or constipation may indicate irritable bowel syndrome*



*Librax has been evaluated as possibly effective for this indication. See Brief Summary.

Recurrent episodes of acute G.I. discomfort, associated with constipation, diarrhea or abdominal pain ranging from dull gnawing to sharp cramping sensations, may suggest irritable bowel syndrome and warrant further investigation. If this tentative diagnosis is confirmed, medical relief of the acute episode may be only the starting point of appropriate long-term management. Such patients often have an extended history of dietary reactions and laxative misuse with a tendency, when under severe emotional strain or fatigue, to experience a colonic "protest."

Indeed, careful questioning will usually uncover a significant relationship between periods of undue anxiety or emotional tension and the exacerbation of G.I. symptoms. This type of patient will probably need your counseling and reassurance to assist him in making beneficial modifications in his life style and attitudes.

## If it's irritable bowel syndrome, consider Librax as adjunctive therapy

In most instances, the patient with irritable bowel syndrome derives maximum long-term benefits from a comprehensive medical regimen directed at both the somatic and emotional aspects of this functional disorder. The dual action of Librax has proved to be highly effective not only in relieving the distressing symptoms of irritable bowel syndrome but also in maintaining patient gains.

## A distinctive antianxiety-anticholinergic agent

**1** Only Librax combines the specific antianxiety action of Librium® (chlordiazepoxide HCl) with the dependable antisecretory-antispasmodic action of Quarzan® (clidinium Br)—both products of original Roche research.

**2** The calming action of Librium—seldom interfering with mental acuity or performance—makes Librax a distinctive agent for the adjunctive treatment of certain gastrointestinal disorders. As with all CNS-acting drugs, patients receiving Librax should be cautioned against hazardous occupations requiring complete mental alertness.

**3** Librax has a flexible dosage schedule to meet your patient's individual needs—1 or 2 capsules three or four times daily, before meals and at bedtime.

## helps relieve anxiety and associated symptoms of irritable bowel syndrome*

# Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

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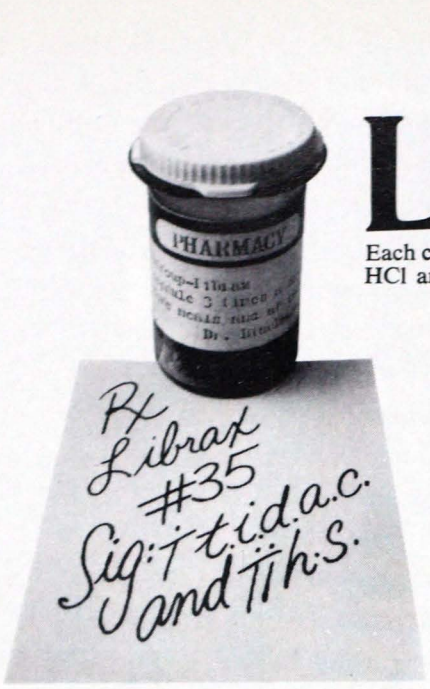
***This drug has been evaluated as possibly effective for this indication. Please see following page for brief summary of product information.**

# Dual-action adjunctive

# Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.




## Initial $R_x$

The initial prescription allows evaluation of patient response to therapy.


## Follow-up

Follow-up therapy, with a prescription for 2 to 3 weeks' medication, usually helps to maintain patient gains.

# helps relieve anxiety-linked symptoms of irritable bowel syndrome* and duodenal ulcer*

**Please consult complete prescribing information, a summary of which follows:**

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are avoidable in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of the mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

**Dosage:** Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

**How Supplied:** Librax® Capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 clidinium bromide (Quarzan®)—bottles of 100 and 500; Prescription Paks of 50, available singly and in trays of 10.

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TEXAS OSTEOPATHIC PHYSICIANS
# JOURNAL

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Mr. Tex Roberts, Editor

# Legislators jump the gun

## as new rule allows for "prefiling" of bills

Although the 65th Texas Legislature won't convene until January, bills are already being "prefiled" and copies of those that are of particular interest to the health care field are being received in the TOMA State Office.

In the coming months TOMA will keep its members informed on such proposed legislation, either in this *Journal* or, if expediency dictates, in the form of a newsletter.

In cases where TOMA has gone on record or has established a policy in regard to certain legislation, this information will be included in the report. In some instances we will ask for comments from members on what they believe the Association's stand should be in regard to the proposed legislation. And in some cases these bills will be published as a matter of information.

In the interest of saving time and space, these reports will be in capsule form whenever possible.

The first of these on which we are reporting, H. B. 89, prefiled by Rep. R. L. Vale of San Antonio, related to "settlement and release of liability" and reads as follows:

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

Section 1. PROHIBITED SETTLEMENTS, RELEASES, AND STATEMENTS. Within 15 days of the date of the occurrence causing injury to any person who is under the care of a person licensed to practice the healing arts or who is confined to a hospital or sanitarium as a patient, no person, firm, corporation, partnership, individual, or agent whose interest is or may become adverse to the injured person may:

(1) negotiate or attempt to negotiate a settlement with the injured person;

(2) obtain or attempt to obtain a general release of liability from the injured person; or

(3) obtain or attempt to obtain any written or oral statement from the injured person for use in negotiating a settlement or obtaining a release.

Section 2 EFFECT OF VIOLATION. Any settlement, release, or statement made in violation of Section 1 of this Act is voidable, and in any court action the settlement, release, or statement shall be presumed to have been obtained under duress or undue influence.

Before damages can be recovered against a doctor and other professionals, the claim would have to be filed with a new Professional Liability Board that would be created under HB 138 prefiled by Rep. Abraham D. Ribak of San Antonio. No suit to recover on a malpractice claim may be filed in a court of this state except on appeal from the Board under provisions of this act which would cover an attorney, physician, dentist, podiatrist, optometrist, chiropractor, professional nurse, architect, registered professional engineer or teacher licensed or certified by the state to practice his profession in Texas.

Legislation prefiled by Rep. Fred Head of Athens would mandate that allopathic and osteopathic physicians educated and trained in Texas would be obligated to serve in rural and inner city underserved areas following licensure and completion of their internships and residencies. One of his bills would mandate that state supported medical schools would be required to place 20 per cent of the student doctors under contract to serve in rural areas.

The purposes of these bills are commendable, but they deny equal protection to student doctors as compared to other professionals being educated and trained at state expense in Texas. There is a shortage of doctors in rural areas and those available to the poor, but this can only be solved by an increase in the numbers of general practitioners trained and licensed.

HB 72 and HB 73 would require, as a prerequisite for admission to a Texas medical school, that the candidate shall have contracted with the Texas

Department of Health Resources to practice in the state for at least two years in a rural or underserved urban area.

His bill, HB 6, would deny state funds to medical schools until at least 20 per cent of the student doctors admitted were obligated by contract to the state to engage in family medical practice for not less than four years. Each student doctor who enters into such contract would be granted $200 a month stipend while enrolled as a medical student.

It is suggested that if the state is going to address itself to the undersupply of physicians in some areas, it should address itself to the oversupply of other professionals being trained at state expense in some areas.

Actually, the admission policies of medical schools and the teaching philosophy must be scrutinized, and greatly increased funding of the Rural Medical Education Board be accomplished. This Board, in the first place, should have a D.O. as a member of it and, secondly, it is charged with the responsibility of recruiting student doctors from rural areas of Texas and supporting them in medical schools with grants, loans and scholarships.

This Board received a token appropriation of $100,000 a year, which is totally inadequate. It could grant support and make loans under a contract that would provide that if the student doctor upon graduation, licensure and completion of his internship or residency would serve in a rural area or urban underserved area; then his financial obligations to the Board could be satisfied on the basis of service in designated areas, or he could pay it off in cash and be a free agent.

TOMA is officially against the creation of any new medical schools in Texas until TCOM and the other state supported medical schools are adequately funded and producing at capacity. TOMA also officially has passed a resolution reaffirming its belief that the uniqueness of the osteopathic school of medicine should not be compromised by combining it with an allopathic school of medicine in Fort Worth and is, therefore, opposed to HB 44, prefiled by Rep. Doyle Willis of Fort Worth, which would establish a medical school by Texas Woman's University. TWU has informed the Coordinating Board about its intention to propose that its Fort Worth campus be combined with one that is also occupied by TCOM.

TOMA officially supports present Texas statutes that prohibit drug substitution by the druggist or anyone else other than the prescribing physician. Mickey Leland, of Houston, has introduced HB 10 which would repeal these anti-substitution laws and, in effect, place the druggist in charge of patient medication.

SB 33, introduced by Sen. Brooks and Sen. Doggett, would permit the druggist to substitute so-called biological equivalent products in filling a prescription. Apparently none of this legislation pinpoints the professional liability in cases of drug substitution.

SB 17, introduced by Sen. Doggett, would empower the Texas Department of Health Resources to regulate fraudulent cancer treatments in Texas. The intent of this bill will receive full support.

HB 87, prefiled by Rep. James J. Kaster of El Paso, would include cancer radiation centers among the facilities eligible to be insured for medical liability by the JUA.

HB 95, by Rep. D. R. Uher of Bay City, would empower the commissioner's court of any county to close any county medical facility. Apparently this authority is needed to be coupled with a county's present authority to build or expand county hospitals and other medical and health facilities.

HB 49, by Rep. Ed J. Harris of Galveston, would amend the state insurance code to provide that the sickness of alcoholism be included in any accident and sickness insurance policies marketed in Texas.

In January and February so many bills will hit the hoppers that it will be difficult to keep up with all of them, but your Association will make every effort to study those that will particularly affect its members in their practices and report to you.

TOMA again appeals to all members to become active in legislative affairs and to let the State Office know which of your state and national legislators you can contact personally when the need arises.

And don't forget that the Texas Osteopathic Political Action Committee (TOPAC) desperately needs more contributors if the osteopathic profession is to be reckoned with in the legislative halls. ^

# Media Reps Participate in TOMA P.R. Seminar

"Turned on" describes Dr. Royce K. Keilers, chairman of the TOMA PR Committee, in his efforts to educate Texans as to the osteopathic philosophy of medicine.

Following a Public Relations Seminar at D/FW Airport Hotel Marina in October, an even 100 press kits, containing information on the profession and the degree D.O., were sent to members of the PR Committee, District PR coordinators and D.O.s who have volunteered to work on PR this year.

Dr. Keilers asked that these press kits be hand delivered to local editors, TV program editors and radio newscasters.

Speakers at the October seminar were Alice Dykeman, Director of Public Relations, Methodist Hospital, Dallas; Jon McConal, Fort Worth Star Telegram; and Bill Hix of KXAS TV Channel 5.

D.O.s attending were Dr. Keilers, Dr. David R. Armbruster, TOMA President, Dr. Richard C. Wiltse, Dr. M. Lee Coleman, III, Dr. Ronald H. Owens, and Dr. Robert A. Komer.

Participating staffs included Janis Odom, Public Information Officer, NTSU; Verlie McAlister, Public Information Officer, TCOM; Carol White, Public Relations Officer, Fort Worth Osteopathic Hospital; and Tex Roberts, TOMA Executive Director and member of the American Society of Association Executives (ASAE) national public relations committee.

The AOA 10-minute slide show on osteopathic medicine was previewed at this seminar, along with a developing slide show from the TCOM Department of Osteopathic Philosophy Principles and Practice.

TOMA has purchased a new slide projector with sound-on cassette. The projector and AOA slides are available for showings wherever D.O.s have an opportunity to present programs to lay organizations.

Quotes from the PR Seminar:

Alice Dykeman said that public relations is a management function providing professional skills necessary to communicate the truth to the general public. You identify your objectives and determine what your priorities are, and you must know what the public thinks. She suggested a speaker's bureau, special sections in newspapers, weekly radio and TV shows.

Jon McConal, contributing editor to the Fort Worth Star Telegram, emphasized that the osteopathic profession and the newspapers need to work together because, in his opinion, we both need each other. He said he liked to concentrate on a good story with a happy ending. (On November 28, he wrote a full page story on the opening of the Justin Clinic, a cooperative effort by TCOM and the citizens of Justin.)

He said the best way to get across the osteopathic philosophy of medicine is to tip reporters off on human interest stories.

Bill Hix pointed out that newspapers, radio and television complement each other; however, television does things that newspapers can't; radio does things that television can't; and newspapers do things that radio and television can't. He cautioned against calling up an editor and complaining about a story that has appeared.

He said television doesn't do much in-depth reporting on the medical profession because no one will watch it. Medical stories are too complicated for TV. He said there is opportunity for public service programs in other than prime time.

In his letters to his PR Committee and volunteers, Dr. Keilers said "Privileged! That is what we are to be osteopathic physicians. The skills that we possess, and the concern for our patients, are the reasons that people come to us in ever-increasing numbers. However, many who have not had personal D.O. contact are ill-informed or uninformed concerning osteopathic physicians and principles. The education of a society as to the osteopathic philosophy, skills and purposes is a huge task. The groundwork that has been laid by those before us must now be carried on by each willing and able osteopathic physician—like yourself."

# "Reasonable Charge" Profiles Updated

*Update of reasonable charge profiles was announced in Physicians Medicare Newsletter No. 53 and Physicians Medicaid Newsletter No. 25 issued in late October. The following information was included in these two combined letters:*

Profile updates have been authorized by the Bureau of Health Insurance (BHI) for Medicare, and the Department of Public Welfare for Medicaid. The target date for actual use of the new profile is October 29, 1976.

This profile update is similar to last year's. The basis for calculation of the physician's *customary charge* from historical charges remains the same; it is the median (half, or middle) of all charges submitted by a physician for a specific service. *Prevailing charges* are still calculated at the 75th percentile. Charges for services provided in calendar year 1975 will be used to calculate both the customary and prevailing amounts.

Beginning with this update, the capability to create both a customary payment level and a prevailing payment level for the *complete range* of medical and surgical services must exist.

### Customary Payment Level

If a claim contains a service for which a customary charge could not be produced from paid claims history for the physician, then a customary level will be calculated. The composite of his charges for other services and their relationship to the given procedure will be used to calculate the customary payment level.

### Prevailing Payment Level

The complete range of procedures are to be included in the prevailing profile for each specialty in each locality. When a prevailing amount cannot be produced from the customary charges of physicians in the same specialty and locality, the amount will be selected from the first available element in specially prepared prevailing profiles, using different combinations of specialty and locality.

| Selection Sequence | Special prevailing profile Description |
|---|---|
| First | The physician's specialty with data from the entire State |
| Second | All specialties within the physician's locality |
| Third | All specialties throughout the entire State |
| Last | The composite of other prevailing charges and their relationship to the given procedure. |

The finally selected amounts are also subject to application of the economic index explained below.

The reasonable charge allowance will be determined by comparing each charge to the customary or the customary payment level; then to the prevailing or the prevailing payment level. The lesser amount will be the allowable charge.

*The economic index requirements remain.* The use of an economic index is a part of Public Law 92-603 which authorized the Secretary of Health, Education, and Welfare to place a ceiling on increases to the prevailing charge. (Note: this ceiling does not affect the customary charge.) *The economic index limitation is 27.6%.* The prevailing charge for each procedure may be increased up to 27.6% above the 1971 charge level used to pay claims at the time Public Law 92-603 was passed. In other words, if the prevailing charge (the charge made 75% of the time for a specific service by physicians of like specialty and locality) increased from the 1971 reference point to the new 1975 charge base by more than 27.6%, the new prevailing must be lowered by applying the limitation.

An example is shown below:

| | |
|---|---|
| Prevailing from 1975 Data - | $600 |
| Prevailing from 1971 Data - | $400 |
| Increase | $200 |

The $200 difference represents a 50% increase and, therefore, exceeds the economic index limitation. The new prevailing will be $400 + 27.6% of $400, or $400 + 110.40 = $510.40, and not $600.

The present prevailings will be "protected" from decrease solely by application of the 27.6% limitation; however, the prevailing *can* decrease when the historical charges for services in 1975 are actually lower than existing profile amounts.

Medicaid profiles will also be updated concurrently with the change in the Medicare profiles, to continue the consistency between the two Programs. Medicaid payments will be based on 95% of the new Medicare allowances. ^

TCOM's Dean Willard says

# Texas needs to provide more intern and residency programs

*When TCOM Dean Ralph Willard, D.O., headlined District III's November 20 meeting in Tyler, he was interviewed by David Barron of the* Tyler Courier-Times-Telegraph. *On November 21 the interview was front page news and Dr. Earl Kinzie of Lindale sent the clipping to this* Journal. *Our thanks to him and our compliments to District III for its continued excellent rapport with the news media. The* Courier *article is reprinted below in its entirety.*

State legislators should concentrate on financing Texas' existing medical schools, rather than open new teaching facilities, the dean of the Texas Osteopathic Medical School (TCOM) said here Saturday.

Dr. Ralph Willard, dean of the school since 1975, was in Tyler Saturday for a district meeting of the East Texas Osteopathic Physicians' Association at the Tyler Petroleum Club.

He said while he does not oppose the establishment of new medical schools in Texas, including a proposed school in Tyler, legislative funding should be used to bring the state's eight existing schools up to their full capacity.

"I think sometimes people forget that of the eight colleges of medicine in Texas, only Galveston and Southwestern have reached their full size," Dr. Willard said. Other schools are at only one-half or two-thirds of their projected levels, he added.

Where improvements are needed, the dean of the Fort Worth school said, is in the number of internships and residency programs provided through Texas hospitals. A lack of such programs is costing the state a number of doctors, he added.

"Some of our medical school graduates leave Texas to get these residencies or internships. It's important to help these teaching hospitals and programs to help keep people in the state.

"I don't think increasing the schools and number of graduates will do it, unless the internships and residencies are provided at the same time," Dr. Willard added.

In another problem facing the medical profession—the distribution of doctors in inner city and rural areas—Dr. Willard said doctors of osteopathy have been more successful than M.D.s in serving these neglected areas.

Some incentives might be necessary to increase the number of doctors in understaffed areas, he said, but legislation requiring a certain percentage of each graduating class to serve in such regions is not the answer.

Established in 1970, TCOM is affiliated with North Texas State University and has graduated 90 students since 1974, Dr. Willard said.

Ground-breaking ceremonies for the school's Medical Education Building I were held last week, beginning a building expansion program at the school that will eventually top $12.8 million, he added.

Osteopathic physicians comprise only five per cent of the doctors in the United States, but divisions between M.D.s and D.O.s (doctors of osteopathy) have healed in recent years and the two branches of medicine cooperate in many activities, the college dean added.

Twenty per cent of all the doctors in the U. S. Air Force are D.O.s, Dr. Willard said, and osteopaths have traditionally gravitated more to primary care—general practice and internal medicine—than have M.D.s.

As a result, osteopaths make up the bulk of the "family doctors" in rural areas across the Midwest, comprising 50 per cent of the rural family doctors in Missouri, he added.

The difference between D.O.s and M.D.s lies in their training, with D.O.s concentrating on the "muscular-skelatal" system—using "manipulative" techniques with the hands to help diagnose medical problems, Dr. Willard said.

Past problems between the two branches have been mainly "political" struggles, with cooperation increasing across the nation, he added. Two osteopaths are on the staff of the East Texas Chest Hospital and assist in TCOM's teaching programs there. ^

# The one the patient takes is never tested.

Surprising, perhaps, but it makes sense when you think about it.

Obviously, the actual dose of any prescription drug the patient takes cannot be tested because it would have to be broken down for analysis—after which it could never be used by a patient.

This means that you depend on the manufacturer for assurance that the dose the patient takes is identical to the ones which have been tested.

At each step in the manufacture of a Lilly drug, test after test confirms the ingredients, formulation, purity, and accuracy—all the critical factors that assure that every Lilly medicine is just what you ordered.

That's particularly important, as you know. The same drug made by different companies can be chemically identical yet may act differently in the human body because of the many variables in the way the drugs are manufactured.

And, of course, government standards alone do not assure the efficacy and consistency—the quality of each drug you prescribe.

As we at Eli Lilly and Company see it, the ultimate responsibility for quality is ours.

For four generations we've been making medicines as if people's lives depended on them.

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# AOHA seeks to stem government regulatory onslaught

Governmental interference is threatening the level of health care now enjoyed in the United States, according to the chairman of the board of the American Osteopathic Hospital Association.

B. A. Zeiher, who also is administrator of Parkview Hospital in Toledo, Ohio, leveled the charge during his remarks before the annual AOA convention in Boston recently.

Zeiher asked member hospitals to take a leadership role in the health services community by pledging to contain the cost of medical care while at the same time keeping the quality of that care at the highest level.

"If we are to fend off big government and its continuing efforts to usurp our prerogatives, we must take a leadership role and be pro-active, not re-active," the board chairman said.

The convention responded to the plea by adopting a resolution outlining several specific ways for hospitals to contain the cost of health care for patients while maintaining the same high quality of care.

The resolution pointed out that hospital costs are under increasing scrutiny by Congress, state and federal agencies, business and industry, insurance carriers and the public.

Hospital and health care costs are affected by advancements in medical technology, public demands for increased services and financial burdens caused by governmental health care programs, the resolution stated.

"Perhaps this will be the catalyst," Zeiher said, referring to the resolution. "We as individual hospitals are able to accomplish little, but as one large, united unit, we will be able to stem the growing regulatory onslaught and preserve the very system — the voluntary system — upon which America was founded."

He added that AOHA hospitals alone cannot beat inflation, but they can set an example for others, "including our overspending governmental bodies."

The AOHA will take steps to fully inform its membership about what the government is doing and proposes to do in the health care field in 1977, according to Zeiher. Proposed national health insurance plans will be of prime concern as they emerge as legislative issues next year.

Association plans for active involvement in governmental affairs include strengthening the relationships between hospital administrators and their congressmen and other key government officials. Another significant effort entails improving liaison with Washington organizations concerned with the health care industry.

Zeiher stressed that active involvement of AOHA members is crucial to success, indeed the very survival of the voluntary hospital system.

"Will you become active with your association in Washington or will you continue to permit the legislators, with lack of information and knowledge, to legislate health care for America?" Zeiher asked the convention. "The future is still in our hands, but it is rapidly slipping through our fingers."

*[Reprinted from News, published by the American Osteopathic Hospital Association, November 9, 1976]*

# FWOH Patients Tune In

Patients at Fort Worth Osteopathic Hospital are the first in Texas to tune into the Patient Information Network (PIN).

Dedicated exclusively to improved communication with the patient, the network televises a variety of health care programs at no charge to the patient on Channel 2, the hospital's free channel.

All patient education programs have been selected to convey health information to the patient. All programs are changed daily, and all have been tested for hospital viewing suitability.

Basic programs, utilizing both live photography and animated drawings, relate to such general health topics as the heart's function, how to avoid muscle strains, why a low-sodium diet is important for some people, first aid procedures, emphysema and how the patient can accommodate breathing limitations, what an x-ray tells the physician, and what a baby's crying can sometimes mean.

The television day begins and ends automatically on the closed-circuit television system. A typical day's programming runs from 7 a.m. until 10 p.m., with the patient educational and informational material available for patient viewing at 10 a.m., 2 p.m., 4 p.m. and 7 p.m. At all other times, a spot announcer accompanied by background music provides the patient with valuable information about hospital services.

In addition to being the first Texas hospital to install a Patient Information Network, FWOH is among the first 20 hospitals nationwide to provide its patients with the numerous health care programs available on a PIN network. Wells National Services, a subsidiary of American Hospital Supply, provides both the electronic hardware and the software programming.

# What does the best health care package look like to TOMA members?

Very complete.

It is a package designed specifically for TOMA members and their employees. And these are just the highlights:

Hospital coverage for 365 days per period of confinement.

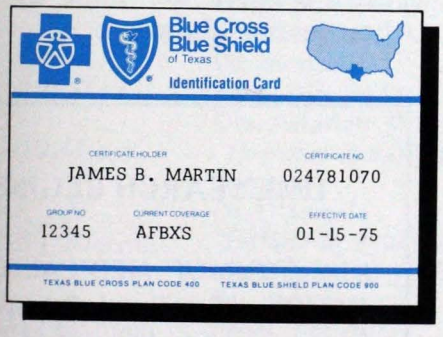
A $30.00 basic room allowance.

Most usual hospital charges covered in full.

Intensive Care and Coronary Care Units covered in full.

A Surgical Schedule for physicians' services.

In addition to the coverages above, $250,000 in Major Medical benefits with a $100 deductible and $65 room allowance. For the first $2,600 in eligible expenses under this Major Medical program, a $100 deductible is applied and the $2,500 balance is paid at 80% during any benefit period. During the remainder of the benefit period, 100% payment will be made under Major Medical for eligible Major Medical expenses exceeding $2,600.

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# Juries Blind to "Real Person"

by Sydney J. Harris

A woman falsely arrested for shoplifting was recently awarded the unprecedented sum of $1 million in damages by a sympathetic jury. The store is, of course, appealing the sum as disproportionate to the injury.

What is important here, I think, is neither the extent of the woman's suffering nor the ability of the (insured) defendant to pay that sum. What is important is the same element that has raised doctors' malpractice insurance premiums to astronomical heights.

One of the gravest consequences of our growing impersonal and corporative society is that the average juryman no longer feels he is penalizing a real person when he assesses huge sums for damages.

* * *

The payer, in most cases, will be a rich and impersonal insurance company; or, if not, its equivalent in terms of a giant food chain, a department store, or some massive corporative conglomerate.

People don't sue other people for huge sums; they sue establishments and institutions that wear no human face. Nobody ever sues a small-town doctor who has been trying to take care of the family within his own limitations; it is the specialist attached to the large urban hospital, hardly known and scarcely seen by the patient, who bears the brunt of malpractice suits. (Largely because the family knows he is heavily insured by a well-endowed company.)

Juries continue to make larger and larger awards in damage suits, not necessarily out of any sense of justice or fair proportion, but mainly because the payers are not viewed as people and the sums will not bankrupt them. There is also a latent sense of "getting back" at impersonal institutions that may have at some time offended or ill-treated the juryman.

* * *

In the end, of course, these huge damages are paid for by the public, in the form of larger premiums; whatever a company pays out is passed along ultimately as a cost to the consumer. But since this cost is spread among many millions, the new effect on each insurance-holder is small—except in such special categories as the medical profession.

A case of false arrest for shoplifting certainly entitles an innocent person to punitive as well as compensatory damages; but $1 million must strike any reasonable person as excessive for such brief harassment and distress. If a small mama-papa shop had caused the woman's arrest, we may be sure the case would have been settled for a few hundred dollars.

There has been an enormous resentment built up against sheer size in our society, especially when it is coupled (as it usually is) with the cold impersonality of bigness. Consequently, there is a kind of malicious pleasure in making these institutions pay through the nose, when the plaintiff is a relatively weak and poor individual. There is no legal justice in this attitude, but justice always runs a poor second to vengeance.

*(Reprinted by permission of Sydney J. Harris and Field Newspaper Syndicate)* ^



# Texas taxpayers get money's worth here

Texas taxpayers are getting more than 100 per cent return on their money spent for the education and training of Doctors of Osteopathy (D.O.s), according to the number of physicians licensed by the Texas State Board of Medical Examiners.

In the year ended March, 1976, there was a net gain of 58 D.O.s practicing medicine in Texas, compared to a net gain of 237 M.D.s for the period. The 58 net gain in practicing D.O.s represents 20 per cent of the overall net gain of 295 physicians practicing in the state for that 12-month period.

The Texas College of Osteopathic Medicine in Fort Worth, graduated 48 D.O.s in the spring of 1976. The Coordinating Board of Higher Education reported 712 M.D.s graduated by Texas allopathic medical schools in the spring of 1976.

State appropriations for the academic year were approximately $230 million for M.D. medical schools and $11.5 million for the D.O. medical school (TCOM).

There are about 12,500 M.D.s in active practice and about 900 D.O.s (7 per cent).

More than 7,000 additional M.D.s practicing in other states hold Texas licenses, and 612 Texas licenses are held by D.O.s who practice elsewhere. ^

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**Program Chairman: David E. Harman, D.O.**

14 (1-A) CME CREDIT HOURS APPLIED FOR

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*Houston, Texas*

David E. Harman, D.O.
*Houston, Texas*

Raymond E. Sorensen, D.O.
*Okemos, Michigan*

Archie B. Attarian, D.O.
*Grand Blanc, Michigan*

Roger D. Monsour, D.O.
*Perry, Michigan*

Vincent F. D'Angelo, D.O.
*Grove City, Pennsylvania*

M. T. Jenkins, M.D.
*Dallas, Texas*

Hyman Kahn, D.O.
*Dallas, Texas*

Paul E. Shutts, M.D.
*Houston, Texas*

Wen J. Chiu, M.D.
*Houston, Texas*

Thomas R.Kain, M.D.
*Houston, Texas*

Robert B. Richardson, M.D.
*Houston, Texas*

Iraj Shaham, M.D.
*Houston, Texas*

S. R. Sellaro, D.O.
*Erie, Pennsylvania*

M. M. Porias, D.O.
*Houston, Texas*

Bruce E. Weaver, D.O.
*Kansas City, Missouri*

Elmer L. Kelso, D.O.
*Arlington, Texas*

## PROGRAM

### FRIDAY, JANUARY 21

6:00– 7:00 p.m. Registration & Reception

7:00– 9:30 p.m. Roundtable Discussion
*"Common Problems in Anesthetic Practice"*
Discussants: Drs. Wiltse, Harman and Sorensen

### SATURDAY, JANUARY 22

7:30– 8:30 a.m. Registration

8:00– 8:45 a.m. *"An approach to Anesthesia for Emergency Surgery"*
Dr. Attarian

8:45– 9:30 a.m. *"Anesthetic Management of Obstetrical Patients and Obstetrical Emergencies"*
Dr. Monsour

9:30–10:00 a.m. Panel Discussion
Drs. Attarian, Monsour and Sorenson

10:00–10:45 a.m. *"Regional Anesthesia for Emergency Surgery"*
Dr. D'Angelo

10:45–11:30 a.m. *"Pitfalls in Fluid Administration to the Emergency Patient"*
Dr. Jenkins

11:30–12:00 noon Panel Discussion
Drs. Jenkins, D'Angelo and Kahn

12:00– 1:30 p.m. Luncheon

1:30– 2:00 p.m. *"Anesthetic Management of Patients with Pheochromocytoma"*
Dr. Shutts

2:00– 2:30 p.m. *"Pain Control"*
Dr. Chiu

2:30– 3:00 p.m. *"Respiratory Therapy"*
Dr.Kain

3:00– 3:30 p.m. Panel Discussion
Drs. Shutts, Chiu and Kain

3:30– 4:00 p.m. *"Muscle Relaxants"*
Dr. Richardson

4:00– 4:30 p.m. *"Considerations in Blood Transfusion"*
Dr.Shaham

4:30– 5:00 p.m. Panel Discussion
Drs. Richardson and Shaham

5:00– 6:00 p.m. Business Meeting

### SUNDAY, JANUARY 23

7:00– 8:00 a.m. Breakfast

8:00– 8:30 a.m. *"Diagnosis and Management of Acute Respiratory Insufficiency and Failure in Patients Requiring Emergency Surgery"*
Dr. Sellaro

8:30– 9:00 a.m. *"Emergency Respiratory Difficulties in Children: Acute Epiglottitis and Laryngotracheobronchitis"*
Dr. Sorensen

9:00– 9:30 a.m. *"Prevention of Aspiration During Anesthesia for Emergency Surgery"*
Dr. Kahn

9:30–10:00 a.m. Panel Discussion
Drs. Sellaro, Sorensen and Kahn

10:00–10:30 a.m. *"An Ophthalmologists View of Anesthesia for His Surgery"*
Dr. Porias

10:30–11:00 a.m. *"Anesthetic Considerations for Cardiac and Vascular Emergencies"*
Dr. Weaver

11:00–11:30 a.m. *"Up and Down and All Around – Sodium Nitroprusside"*
Dr. Kelso

11:30–12:00 noon Panel Discussion
Drs. Porias, Weaver and Kelso

12:00 noon Adjourn

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# For Postage Sake, Keep Us Informed

Recently the Postal Service has been running a TV commercial, touting the availability of a kit to be used by postal patrons who are planning to change their addresses. We hope some of you have been watching!

Because as of July 18, it has been costing you as much as 70¢ to *not* get your monthly *Journal*. --And that's just postage fees.

First, it costs close to a dime just to mail you a copy. And if you have moved, or if the postal service has changed your zip code (or your post office, as was the case with Bedford and Euless), your State Office gets your *Journal* back, or a small envelope with your mailing label in it (sometimes with your new address). On the outside of the envelope, printed in large black letters, is the message, "*Postage Due* 25¢.

Now since sometimes it takes as much as three weeks for delivery of the *Journal*, by the time we learn we have the wrong address for you, it is too late to correct it before the next issue is mailed. So there goes another dime to mail it, and another quarter to get the news again that Doctor _____doesn't live here anymore.

With postal rates continuing to escalate, this year more than $8.00 of each member's dues will go for postage. Most of this is money well spent. But every effort is made not to waste *any* of your dues money. There are too many services that could be performed if money was available.

When you change your address, it will cost you 9¢ to send us a postcard well in advance of your moving date. We can get your address changed on time, you won't miss any important mailings, and the TOMA postage bill will be lowered substantially. ^

# SO SOON OLD

Man's generally accepted three score and ten years is usually considered a ripe old age in temperate climes, an age that many do not reach. In the US anyone who reaches 100 can expect a letter from the president and his or her picture in the paper.

But in the southern Caucasus, between the Black Sea and the Caspian, it is not unusual to find many people still spry and active at well over 100. A 130 year old woman recently danced on Russian TV. She also smoked cigarettes, drank vodka, and tended a vegetable garden. She was not unusual. A man of 120 a few years ago married a 40 year old woman and sired three children. A family of five brothers, all hearty, are 109, 107, 105, 98, and 92.

What is there about the air or land, or perhaps the inherited genes of the local people, that enables them to live commonly to ninety and one hundred, and some much older? The people use tobacco in moderation, drink their own good white wine of rather low alcohol content, and drink strong tea. They eat little salt and less refined sugar. But they are fond of hot spices and consume prodigious quantities of honey. They are also fond of fruits, nuts, vegetables, and spring water.

Two pounds of cheese and other dairy products a day are normal, along with large quantities of homemade yogurt. Most meat is prepared free of fat, by broiling or boiling. Fresh food is considered important. There is very little eating of leftovers, and children are not urged to clean their plates. Few people overeat and fat people are considered to be sick. The diet seems to be simple and much the same throughout life.

Most of the oldsters are farmers or herdsmen and live in small villages in the mountains. There is little striving to change one's position in life. Much value is placed on family and friends with little reaching for material possessions.

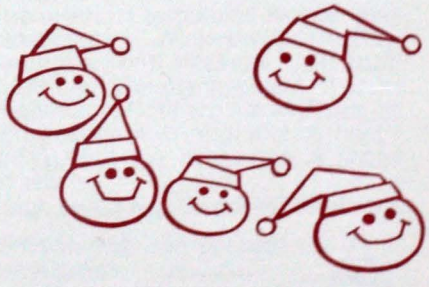
Children are carefully taught the "right thing to do" by any of the five generations there may be in the family. The oldest in the home, whether male or female, is always head of the household and sits at the head of the table.

It is customary for an adult male to ask his father if he may smoke in his presence or remove his jacket in the house. Marriages are seldom consummated in less than a year after the wedding. Education is considered secondary to bravery, self-restraint and resourcefulness.

So why do so many of these people live disease free long after so many of us are in a nursing home or the cemetary? It is worth noting that seldom is an oldster seen who is not working at something, and quite vigorously. There is no talk of age, nor is anyone considered ready for the pasture at some specific time.

Everyone lives his life in small quite villages in the security of his family, eating always the same but healthful food and doing the same energetic work for a lifetime. It's a life of consistent values with a "strong biological and spiritual rhythm." And the same magic is open to anyone, anywhere.

*(Reprinted from* The Curtis Courier, *Autumn 1976)* ^



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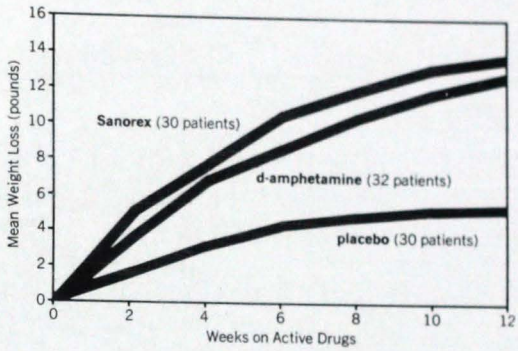
During the 12-week phase of active medication in conjunction with dietary restriction, patients on Sanorex lost an average of 14.06 lb, compared with 13.06 lb for d-amphetamine and 5.63 lb for placebo patients.




1. Vernace BJ: Controlled comparative investigation of mazindol, d-amphetamine, and placebo. Obesity/ Bariatric Med 3:124, 1974.

**Indication:** In exogenous obesity, as a short-term (a few weeks) adjunct in a weight-reduction regimen based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors.

**Contraindications:** Glaucoma; hypersensitivity or idiosyncrasy to the drug; agitated states; history of drug abuse; during, or within 14 days following, administration of monoamine oxidase inhibitors (hypertensive crisis may result).

**Warnings:** Tolerance to many anorectic drugs may develop within a few weeks; if this occurs, do not exceed recommended dose, but discontinue drug. May impair ability to engage in potentially hazardous activities, such as operating machinery or driving a motor vehicle, and patient should be cautioned accordingly.

*Drug Interactions:* May decrease the hypotensive effect of guanethidine; patients should be monitored accordingly. May markedly potentiate pressor effect of exogenous catecholamines; if a patient recently taking mazindol must be given a pressor amine agent (e.g., levarterenol or isoproterenol) for shock (e.g., from a myocardial infarction), extreme care should be taken in monitoring blood pressure at frequent intervals and initiating pressor therapy with a low initial dose and careful titration.

*Drug Dependence:* Mazindol shares important pharmacologic properties with amphetamines and related stimulant drugs that have been extensively abused and can produce tolerance and severe psychologic dependence. Manifestations of chronic overdosage or withdrawal with mazindol have not been determined in humans. Abstinence effects have been observed in dogs after abrupt cessation for prolonged periods. There was some self-administration of the drug in monkeys. EEG studies and "liking" scores in human subjects yielded equivocal results. While the abuse potential of mazindol has not been further defined, possibility of dependence should be kept in mind when evaluating the desirability of including the drug in a weight-reduction program.

*Usage in Pregnancy:* An increase in neonatal mortality and a possible increased incidence of rib anomalies in rats were observed at relatively high doses.

Although these studies have not indicated important adverse effects, the use of mazindol in pregnancy or in women who may become pregnant requires that potential benefit be weighed against possible hazard to mother and infant.

*Usage in Children:* Not recommended for use in children under 12 years of age.

**Precautions:** Insulin requirements in diabetes mellitus may be altered. Smallest amount of mazindol feasible should be prescribed or dispensed at one time to minimize possibility of overdosage. Use cautiously in hypertension, with monitoring of blood pressure; not recommended in severe hypertension or in symptomatic cardiovascular disease including arrhythmias.

**Adverse Reactions:** Most commonly, dry mouth, tachycardia, constipation, nervousness, and insomnia. *Cardiovascular:* Palpitation, tachycardia. *Central Nervous System:* Overstimulation, restlessness, dizziness, insomnia, dysphoria, tremor, headache, depression, drowsiness, weakness. *Gastrointestinal:* Dryness of mouth, unpleasant taste, diarrhea, constipation, nausea, other gastrointestinal disturbances. *Skin:* Rash, excessive sweating, clamminess. *Endocrine:* Impotence, changes in libido have rarely been observed. *Eye:* Long-term treatment with high doses in dogs resulted in some corneal opacities, reversible on cessation of medication; no such effect has been observed in humans.

**Dosage and Administration:** 1 mg. three times daily, one hour before meals, or 2 mg. once daily, one hour before lunch. The lowest effective dose should be used. Should GI discomfort occur, mazindol may be taken with meals.

**Overdosage:** There are no data as yet on acute overdosage with mazindol in humans. Manifestations of acute overdosage with amphetamines and related substances include restlessness, tremor, rapid respiration, dizziness. Fatigue and depression may follow the stimulatory phase of overdosage. Cardiovascular effects include tachycardia, hypertension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting and abdominal cramps. While similar manifestations of overdosage may be seen with mazindol, their exact nature have yet to be determined. The management of acute intoxication is largely symptomatic. Data are not available on the treatment of acute intoxication with mazindol by hemodialysis or peritoneal dialysis, but the substance is poorly soluble except at very acid pH.

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Three AOA-approved residencies are available at Grand Prairie Community Hospital. They are in anesthesiology under Elmer Kelso, D.O.; general surgery under J. N. Stewart, D.O.; and orthopedics under T. T. McGrath, D.O. Qualified D.O.s should apply immediately by contacting Mr. Richard D. Nielsen, administrator, Grand Prairie Community Hospital, 2709 Hospital Boulevard, Grand Prairie, Texas 75051.

## DR. McGRATH AWARDED FELLOWSHIP

T. T. McGrath, D.O., of Bedford, recently was awarded a fellowship in the American Osteopathic Academy of Orthopedics at its annual meeting in New Orleans. Dr. McGrath was one of ten receiving fellowships. It was the first year for such awards by the Academy.

## CME CREDITS FROM AS FAR BACK AS THREE YEARS MAY STILL BE REPORTED

D.O.s who earned continuing medical education credits since the start of the AOA program in 1973 may still report them if they have never done so. Any unreported credit hours acquired since June 1, 1973, may be sent to the AOA Office of CME to be applied to the requirement of 150 hours for the first three-year program—which ends December 31, 1976. There will be no carry-over of credits; an entirely new program will begin on January 1, 1977.

## NATION'S FIRST "RIGHT-TO-DIE" LAW

The nation's first "right-to-die" law has been enacted in California, permitting terminally ill patients to refuse artificial life-supporting procedures by signing a "living will" in the presence of two witnesses, neither of whom can be the patient's relative, physician, heir or a hospital employee. The attending physician cannot be held liable for the patient's death and insurance companies are not permitted to classify the death as suicide for the purpose of denying life insurance payments.

## FREDERIC H. BARTH DIES

Dr. Frederic H. Barth, chancellor and former president of Philadelphia College of Osteopathic Medicine died November 6, in the hospital named in his honor—Barth Pavilion Hospital of PCOM. He was 76. Dr. Barth had been active on the board of trustees of PCOM since 1948, and served as the college's chief executive officer from June 1957 to June 1974, when he was appointed chancellor.

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ASSOCIATIONS WIN TAX RELIEF:

# Tax Reform Bill Kills Trade Show Tax and Ban on Foreign Convention Deductions

Associations have won tax relief in two areas of the massive Tax Reform Bill that President Ford has announced he will sign October 2.

The 1976 Tax Reform Bill, which took nearly a year to produce and contains hundreds of changes in the tax code affecting businesses, individuals and associations, has two provisions specifically aimed at voluntary trade and professional associations.

The first of these, Section 2105, holds that income from qualifying association conventions and trade shows will not be subject to unrelated business income tax.

President James P. Low, CAE, American Society of Association Executives (ASAE), said this provision is essential to trade and professional associations who provide their members with convention and exhibits displaying new products and services. ASAE has opposed the trade show tax since it was first announced by the Internal Revenue Service last December.

Section 2105 and its related legislative history exempts from unrelated business income tax trade shows sponsored by associations which regularly conduct conventions and exhibits to stimulate interest in, and demand for, industry products or services.

Besides industry shows, the provision covers association supplier shows as well as those shows sponsored by scientific, technical and educational organizations exempt under Section 501(c)(3) of the tax code. Although Section 2105 does not specifically mention shows sponsored by organizations exempt under 501 (c)(3), the colloquy between Senators Talmadge and Long (See Box) and the relevant legislative history at the time of passage clearly indicates the Congressional intent to include these organizations.

The exemption for conventions and trade shows applies to taxable years beginning after the date of enactment.

Another provision, Section 602, rejects stringent language adopted in an earlier bill barring tax deductions for delegates attending conventions, educational seminars and similar meetings outside North America. Low said the exceptions to this ban were so "vague and ambiguous" that few associations would consider holding overseas meetings.

## *Supplier Shows and Exempt Organizations Covered by Trade Show Amendment*

A September 16 colloquy between Senators Herman Talmadge (D-Ga.) and Russell Long (D-La.) on the Senate floor just prior to the final vote on the Tax Reform Bill clarifies coverage of association supplier shows and 501 (c)(3) organizations under the Trade Show Amendment:

"Mr. TALMADGE. Section 2105 overrules the principle of a series of rulings (TIR-1409, 1975-2 CB 202-226 in which the Internal Revenue Service indicated that tax-exempt organizations had unrelated business taxable income from renting display space at their convention trade shows to exhibitors permitted to make sales. Under Section 2105, renting display space is not an unrelated trade or business where the sponsoring organizations use trade shows to promote and stimulate interest in, and demand for, their industries' products in general or where the sponsoring organizations use trade shows to educate their members regarding developments, products, and techniques available to them. Thus, it is my understanding that both the so-called industry show and the so-called supplier show are a qualified trade show activity within the meaning of the new code section 513(d)(3)(B).

"Mr. LONG. That is correct. Such activities do not result in unrelated business income to the sponsoring organizations."

Under the compromise provision that will apply to association conventions taking place after December 31, 1976, deductions will be allowed for expenses incurred by those people attending not more than two conventions outside the United States in a taxable year. The amount of the deduction for transportation expenses to and from foreign conventions can not exceed the cost of air fare based on coach or economy class charges. Transportation expenses will be deductible in full if more than one-half of the total days of the trip, excluding the days of transportation to and from the convention, are devoted to business-related activities. If less than one-half of the total days of a trip are devoted to business-related meetings, a deduction will be allowed for transportation expenses in the ratio of the business meeting time to total time.

Deductions for subsistence expenses such as meals, lodging, and other ordinary and necessary expenses, paid for or incurred while attending the convention will be limited to the per diem allowed government employees at the location where the convention is held.

These subsistence expenses can be deducted only if the convention delegate attends two-thirds of the business sessions. In order to deduct subsistence expenses up to full per diem allowance, the convention will have to schedule at least six hours of business sessions to count as a full day, and at least three hours to count as a half day.

Reporting requirements are also covered in Section 602. A delegate must furnish with his tax return information indicating the number of hours of each day and the total number of days of transportation to and from the convention that are devoted to business-related activities. The delegate must also attach to his tax return a program or agenda of the convention and a signed statement by an officer of the sponsoring organization indicating the total number of convention days and the number of hours of business meetings that the delegate attended each day.

ASAE is working to be sure that realistic per diem rates are established for foreign travel. Early next month the ASAE International Committee will meet to prepare a "Guide to Foreign Convention Attendees" explaining in detail the new rules on deductions for overseas travel and the record keeping requirements. ASAE will also provide members with standard reporting forms that can be used when holding foreign meetings.

ASAE President James P. Low, CAE, announced the ASAE Board at its meeting next month will focus on the current tax treatment of association advertising and subscriptions. Low said ASAE's highest legislative priority is to correct the inequities in the rules issued by the IRS allocating membership dues as subscription income.

# *The Modern D.O.*

## *An Audio-Visual Presentation*

A new audio-visual presentation dramatizing the story of the osteopathic profession is now available for showing from the American Osteopathic Association.

Prepared by AOA's Department of Public Relations and an independent audio-visual company, the new program is available in either slide or filmstrip format. Filmed on location in color, the program's action scenes demonstrate the increasingly important role played by osteopathic physicians in delivering health care to the American people.

Narration, music and taped interviews with osteopathic physicians are interwoven to dramatize the story of the modern D.O. In their own words, the physicians explain the rigorous educational and training process required to become a D.O., the profession's unique philosophy and its emphasis on family practice, and why they feel they have chosen the most rewarding of all professions.

Both program formats are under ten minutes in length. Suggested target audiences for the program are students, civic and fraternal organizations, business groups, and community opinion leaders.

Cost of the slide plus tape cassette program is $40; the filmstrip is priced at $30. Orders and inquiries should be directed to: AOA Department of Public Relations, 212 East Ohio Street, Chicago, Illinois 60611.

# How may we serve you—better?

In an effort to pinpoint the greatest prevailing problem in any association, we would have to say it is lack of communication. But when "there are none so blind as those who will not see, and none so deaf as those who will not hear," *HOW* can you communicate?

If you're reading this, you are among the estimated 33 per cent of the membership that has its eyes and ears open, so we *are* communicating with you. Now, how do we reach the other 67 per cent?

If they don't read this *Journal* or other information emanating from the State Office; if they don't go to District or State meetings; if their main news source comes from TV, how do we reach them?

This year's TOMA Public Relations Committee is possibly one of the most active we've had in years. It has done its utmost to reach all members. It has asked for active participation of the membership, and has received assurance from a rather large number of willingness to help. But when Chairman Royce Keilers arranged an interesting and informative meeting recently, inviting all those who had responded to his call for help, seven members showed up. (He still maintains his optimism!)

In the light of this, does any member have the right to grouse about poor professional public relations?

Recently the Pennsylvania Osteopathic Medical Association sent a questionnaire to each of its members. Some of the questions included in it were:

Do you participate in your District affairs?
Do you participate in the affairs of POMA?
What changes do you feel should be made in the operation of POMA?
Do you feel that the Board of Trustees represents you well?
Do you think that the POMA Board understands your problems?
Is the POMA operating to your satisfaction?

Of the 1,448 members, 522 responded to the survey and a number of their responses were printed in the POMA Newsletter.

In studying these responses, we would have to conclude that of a little more than one-third of the membership that responded, there was a woeful lack of knowledge of the ongoing Association programs. And *that* from the third who were interested enough to take the time to participate in the survey.

What of the other two-thirds? Since the one-third that cared enough to respond had not kept themselves well-informed of their Association's programs, we might reach the conclusion that the bulk of the members were either apathetic, ill-informed, or (as we often suspect here) don't read their mail, or their front office considers any form letter a candidate for the wastebasket.

Although the Pennsylvania Association only publishes its *Journal* quarterly, it does put out a very informative monthly Newsletter. If a member would take as little as 30 minutes a month perusing these publications, he would at least know what his Association is trying to do in his behalf, and perhaps would have a little better understanding of what is actually being accomplished on a day-to-day basis.

To return to the questions posed in the survey:

A little more than half of the respondents said they participated in District affairs, and fewer said they participated in POMA affairs.

When asked if they felt that the Board of Trustees represented them well, 39 per cent *didn't know!* And to the question of whether they thought the Board understood their problems, 37 per cent didn't know. As to whether POMA was operating to their satisfaction, 31 per cent had no opinion.

From this, we deduce that little more than ten per cent of the entire POMA membership was keeping itself informed of Association activities. And the information is being dispensed. We know because we are on the mailing list to receive all communications that are regularly mailed to the POMA members.

Figuring the responses on a percentage basis, about 15 per cent of the total membership felt that the Board was representing it well and that it understood their problems; while less than 19 per cent felt that POMA was operating to its satisfaction.

We hope these figures lie and that the more than 900 members who did not respond simply didn't get around to it—for various reason—but that they are interested and satisfied with their professional association. We can hope the lack of response was due to satisfaction in the status quo, or at least complacency.

POMA is not being singled out as being better or worse than any other professional association. We fear the situation is normal; that very similar responses would come from such a survey of TOMA members, or those in Oklahoma, Michigan, Florida, or you name it!

In addition to the *TOMA Journal,* numerous other mailings are sent to our membership. (Our postage budget this year was projected at $5,500!) Annually your President tries to visit most Districts and bring you more information.

Some years ago the Board set a policy that the Executive Director should visit each District at least biennially—on invitation from the Districts. Great idea! But those invitations have been few and far between.

We would greatly appreciate the opportunity of bringing an informative program to each District; one that would explain the work being done in your State Office, and answer any questions you might have concerning that work or any of the many programs being carried on by your Association.

So, as we said in the beginning, it's a problem of communication. We'll supply any information you want; and we would appreciate the opportunity to correct a lot of *mis*-information.

How may we serve you—better? —Tex Roberts.

# Faith Burt is NOGA President-Elect



Mrs. Faith Burt, director of the Department of Volunteer Services at Fort Worth Osteopathic Hospital, will assume office as president of the 1,400-member National Osteopathic Guild Association (NOGA) next September in Lubbock.

In October Mrs. Burt traveled to Massillon, Ohio, where she was officially installed as 1976-77 president-elect before a national audience which gathered for the association's 21st annual convention. The president-elect also served this 21st meeting as NOGA's national chairperson.

When Mrs. Burt takes on the responsibilities as NOGA president in 1977, she will be the third Texan ever to do so. Mrs. Hattie Elmore of Lubbock and Mrs. Mattie Lewis of San Antonio have also served in that capacity.

A native Texan, Mrs. Burt has previously served NOGA as vice president, recording secretary and corresponding secretary.

Mrs. Burt has been with FWOH for more than 20 years, first as a hospital volunteer and for the last 11 years as director of the hospital's growing volunteer program. She has been elected to serve in every office of the FWOH Guild.

Mrs. Burt holds professional memberships with the Texas Hospital Association, the Texas Association of Hospital Auxiliaries and the Tarrant County Association of Volunteer Directors. She has also served on the Advisory Board of the Retired Senior Volunteer Program which is sponsored by the Tarrant County Community Council.

Dr. George J. Luibel, president of the American Osteopathic Association, offered the keynote address before the national audience at the NOGA convention and chose to comment on "The Art of Serving." Dr. Luibel is president of Fort Worth Osteopathic Hospital, Inc., and is a long-time member of the hospital's Board of Directors.

Mrs. George J. Luibel, wife of the AOA president, was also on the convention program, speaking on the "Power Within You." She is a past president of the Auxiliary to the American Osteopathic Association.

Also included on the program were Mr. and Mrs. Raymond Fetter. Mrs. Fetter, now president of the FWOH Guild, delivered the opening address and later participated on a panel which examined the junior volunteer program in the hospital. Her husband, also a member of the FWOH Guild, delivered the invocation at the four-day meeting. ^

## *DISTRICT II*

**by Nancy M. O'Shea, Public Relations Chairman**

September and October have been busy months for the District II Auxiliary. We have many new members this year. Beverly Proffitt, our Auxiliary President, presided over a luncheon at the Fort Worth Club on September 16 and Anne Quinn of the Fort Worth National Bank spoke to us on "Making Life a Little More Simple." On October 9, the new members and their husbands were honored with a special party at Joe T. Garcia's. Thursday, October 28, the Auxiliary boarded buses for an "Underground Shopper" trip to Dallas.

The Hospital Fine Arts Project is making progress thanks to cash donations and gifts of paintings and frames. We soon will head to Fort Worth Osteopathic Hospital to begin hanging the paintings. Finally, Mr. Dennis Bartz of the Fort Worth Museum of Science and History has assured us that "Osteopathic Medicine" will be added to the Hall of Medicine exhibit at the Museum. ^

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# Trimming the Trivia out of our Projects

"So little time is spent in planning, in research, in thinking through what is important, what predictable changes in society must we be ready to face *in advance* of the day they become reality.

"So much time is spent on minor affairs, which will have little if any effect on the total membership in the future years. To uselessly carry out the same trivia the association has been involved in during the past many years is of little consequence."

The above is an excerpt from a letter from Mr. Lloyd Hall, Executive Secretary of the Kansas State Osteopathic Association, written to Mr. Robert P. Chapman, Executive Director of the New Jersey Association of Osteopathic Physicians and Surgeons and Secretary of the Association of Osteopathic State Executive Directors (AOSED).

The letter was prompted when Mr. Chapman asked Mr. Hall if he would update a paper he had written in 1962; "How to Get an Association Working on Worthwhile Projects." Although that paper was written for Association Executive Directors and Secretaries, much of it applies directly to the officers and committees, as well as the individual members of a state osteopathic association.

Mr. Hall begins by commenting on the title. He says, "This is an intriguing and compound title. Basically it resolves itself into two subjects and their combination:

1. How to get an association working
2. How to select worthwhile projects
3. How to get them working on the worthwhile projects."

He says that considerable time should be devoted to the *selection* of programs which will truly accomplish something for the good of the membership, and that this is one of the most difficult tasks. "It is too easy to continue to do a project simply because it has been done for 10 or 40 years without re-examining its real significance to the total association program. It is also easy to add nothing new because any project we add takes time, effort and money."

He goes on to say that association members have various needs that can be met partially through association programs. First on his list of such needs is "Greater recognition at all levels of government."

This has been an ongoing project for TOMA for a number of years, but there are still several areas in the health care field where our members have no representation. In addition to obtaining membership on state boards, councils and agencies, individual members and Districts should be at work to obtain representation on local and county agencies.

In the public relations field, Mr. Hall suggests working for "greater recognition in the community". This is another area where TOMA is already particularly strong with regard to its various programs, but it is another field where individual members can accomplish much.

Mr. Hall says, "We should encourage doctors to be physicians for their local sports teams, hold postgraduate educational courses in various areas of the state, feature local doctors as top speakers on scientific subjects at these meetings. Do these things and many others to increase their standing, and again you increase their respect for themselves, their profession and their degree."

"Among our projects must be some which give to the doctor and the members of his family a sense of belonging to something vital, something growing, and something great.

"I deplore discussions on negative versus positive thinking, yet we must avoid giving our members any reason for adopting a defeatist attitude. Everyone wants to be associated with something which is successful. If we can maintain the feeling of vitality and growth in the profession, and help convince our members that this is one of the most successful and vital professions of all time, many other problems will disappear.

On the subject of selecting worthwhile projects, he says, "People will work once they are convinced that the project is important. Each project should be the most important project of all time. Undoubtedly the projects you had one or five years ago were vital, but this is the project you are working on now, and its successful conclusion is the most important single project facing you today. . . . . .

"Doctors are pretty smart people. They will detect at once the make-busy project having little or no significance. They will rebel against wasting their time on something they are convinced is not of vital importance.

"All of us fall short in the execution of the programs. We either pay too little attention to the selection of worthwhile projects, or we fail in imparting our own enthusiams to our members, or in providing the members with the necessary information and tools for carrying out the project.

"But the salvation of the osteopathic profession to date has been their unstinting willingness to work on projects which they were convinced are worthwhile. If the membership everywhere could be convinced maintenance of the osteopathic profession was one of the most important things on the entire health scene today, and that actions or projects were vital to the maintenance of this profession, this profession would get the job done." ▲

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# LETTERS

*The following letter was written to the editor of the* Dallas Times Herald *and printed in its issue of November 4. The thoughtfulness of Mrs. Bob Lutz in sending it to us is appreciated–Ed.*

I would like to correct a statement in Saralee Tiede's story on the recent meeting of the Coordinating Board Texas College and University System, which appeared in the Oct. 17 issue of your newspaper.

Ms. Tiede wrote, as an indirect quote from Commissioner of Higher Education Kenneth Ashworth, that "there are still 23 counties in Texas without a physician, but eight of those counties have a licensed osteopath..."

The report from which Dr. Ashworth was quoting at the meeting in Austin notes, "In 1974 there were 23 counties in Texas without an active MD. However, eight of these counties did have a DO licensed to practice medicine in the county."

Doctors of osteopathy, or osteopaths as they are often called, are fully licensed physicians. Both DO and MD candidates in our state take the same licensing examination and are licensed by the same Texas State Board of Medical Examiners, a 12-member group composed of nine MDs and three DOs.

Ms. Tiede's report from Austin is indicative of the lack of public understanding about the osteopathic medical profession. Now that Texas has a state-supported osteopathic medical school, the Texas College of Osteopathic Medicine, which is under the governance of the North Texas State University Board of Regents, we hope that the citizens of Texas will become more knowledgeable about this phase of medical practice.

DOs and MDs receive parallel and almost identical education, and the major differences between the two branches of medicine are philosophical and historical.

Janice Odom
Director
Public Information and
Publications
North Texas State University

Dear Sirs:

On June 11, 1976, we sent you an update for your Membership Directory. However, on perusing the present Directory you have failed to make the correction as described in regard to my certification. We would urge you to correct this oversight in your next issue.

Sincerely yours,
T. J. Tuinstra, D.O.

Dear Dr. Tuinistra:

Each year when we begin preparation of copy for our Membership Directory, we write to the secretaries of the specialty colleges and ask them for a list of their Texas members, and to indicate whether they are certified or fellows in their particular societies.

We feel that their information should be complete, accurate and up-to-date and that each society should be the reliable source for us to contact, and we hesitate to question their accuracy.

We do have Ms. Scoma's letter of June 11 concerning your certification, and perhaps we committed the sin of omission in not questioning ACOS further, since it is obvious we are all subject to errors.

Regardless, we do apologize and are calling this to the attention of the American College of Osteopathic Surgeons through a copy of this letter. Between us, we'll try to get it right next year!

Cordially,

Tex Roberts, CAE
Executive Director

Dear Mr. Roberts:

Again I am writing you and as usual it is to thank you for TOMA's support of SOMA. As in the past, your support has enabled this chapter to be in the position to learn and grow, to better serve the students of TCOM. Some results from these meetings are: a seminar on female reproductive physiology we will bring to TCOM in a few months, expansion of our spring symposium on death, an enormous amount of information on financial aid and the growth of osteopathic medical education.

We will keep in touch on programs we give so that any interested TOMA member will be able to attend. Again thank you for your support of SOMA.

Gregg Lund
TCOM member,
National SOMA Board of Directors

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## OPPORTUNITIES FOR OSTEOPATHIC PHYSICIANS IN TEXAS

HOUSTON: Clinic with active practice for lease or sale. Close vicinity of excellent D.O. hospital. Gross annual income 90,000 plus. Terms negotiable. Owner can finance. Write or call: TOMA, Box T, 512 Bailey Avenue, Fort Worth, 76107, phone 817—336-0549.

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TEXAS—Certified ophthalmologist (D.O.) would like to relocate. Contact Mr. Tex Roberts, 512 Bailey Avenue, Fort Worth, Texas 76107.

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HOUSTON—General Practitioners and internists needed in expanding Texas Hospitals. Guaranteed income. Group and solo practices available. No fee. Excellent facilities. Send curriculum vitae to: Director, P. O. Box 2128, Houston, Texas, 77001.

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PEDIATRIC RESIDENT — Will conclude residency August 1977; now looking for permanent location for pediatric practice. Contact Gerald L. Dickman, D.O., 7232 NW 11th, Oklahoma City, Oklahoma, 73217.

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DALLAS—Well established, successful and financially rewarding practice. Architecturally designed building suitable for two plus general physicians or specialists available for lease or purchase. Building 20 minutes from any place in Dallas and only 5 minutes from D.O.H. Reason for leaving - full time faculty position with T.C.O.M. Contact John H. Harakal, D.O., 3516 Camp Bowie Blvd., Fort Worth, Texas 76107. 817—338-9011.

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KNOX CITY—This North Texas community welcomes a D.O. Staff privileges on Knox County Hospital, associateship, excellent gross existing. Contact Glen Rumley, Knox County Hospital, 817—658-3535.

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FORT WORTH—Texas College of Osteopathic Medicine needs G.P.s as faculty members in Department of General and Family Practice. Expanding clinical and academic program. Request C.V. and/or contact L. L. Bunnell, D.O., Chairman, 3516 Camp Bowie Blvd., Ft. Worth, Texas 76107. 817—731-2741.

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GRAHAM—Plans are underway for building a new clinic on the banks of Possum Kingdom Lake. Excellent opportunity for two General Practitioners. D.O.s welcome on the professional staff of 40-bed general hospital. Population: 9,000 in city; 12,000 plus in total area. Financial incentives available. Contact Mr. Howard Thurmond, 817—549-3500, 446 Elm Street or Mr. C.G. Young, Administrator, 817—549-3400, P.O. Box 690, Graham, Texas 76046.

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WANT TO RELOCATE: Surgeon who will do general practice wants to relocate in central or south Texas. Age: 59. Write Box P, TOMA, 512 Bailey Avenue, Fort Worth, 76107.

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(For information call or write Mr. Tex Roberts, Executive Director, TOMA Locations Committee, 512 Bailey, Fort Worth, Texas 76107, 817—336-0549.)

TROUP—Excellent opportunity in East Texas. Share established practice with only physician in area. Separate rent free office available. Hospital facilities nearby. Nursing home. Good location easily accessible to major cities. Contact Carl F. List, D.O., 705 West Duvall, Troup, Texas 75789. Call 214—842-3366 or 214—842-3325.

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DALLAS—Oak Cliff Medical Center and Hospital (including 3 clinics) needs General Surgeon willing to do General Practice and 2 G.P.s. Busy E/R and Outpatient; daily referrals. Fully equipped rent free office. Contact C. Richard Harrell, Administrator, South Oak Cliff Medical Center, 728 S. Corinth, Dallas, Tx. 75203. Call 214—946-4000.

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HOUSTON—Professional Medical & Surgical Clinic Association has openings for Specialists in the fields of Int. Medicine, Pediatrics, General Practitioners, General Surgery, OB-Gyn. Contact Chris S. Angelo, D.O., 2902 Berry Road, Houston, Texas 77016. Phone 713—695-5149 or 713—335-4881.

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POSITIONS OPEN for several beginning General Practitioners to establish local private practice and provide emergency room services for a 127-bed hospital, starting July 1, 1977. Contact R. J. Halbrook, Administrator, East Town Osteopathic Hospital, 381—7171, Ext. 68.

# PSRO Poll leaves HEW in Quandary

HEW secretary David Mathews is pondering what to do with the results of a poll in which Texas physicians were asked whether they favor a single, statewide Professional Standards Review Organization (PSRO) in the Lone Star State.

About 11,000 of Texas' 16,000 physicians responded and voted overwhelmingly in favor of a single PSRO. The voting was advisory, however, and Mathews is not obliged to respond with designation of a single, statewide PSRO although he is understood to favor doing so.

A federal court had overturned HEW's designation of multiple PSROs in Texas. (The above is taken from the nationally circulated prestigious McGraw-Hill Washington Report on Medicine and Health.)

Meanwhile, back at the D/FW Airport Marina Hotel late in November, the Executive Committee and the Board of the Texas Institute for Medical Assessment (TIMA) received additional information that there were no "negative" pockets in the map of Texas when the 11,058 ballots were counted, with 86 per cent (9,532) voting for a single, statewide PSRO, and 14 per cent (1,526) favoring multiple PSROs.

TIMA has in readiness an application for a PSRO planning grant if and when the HEW secretary designates Texas a single area.

Representatives of TIMA plan to be in Washington during the week of December 6. The 16-man TIMA Board is composed of four D.O.s, ten M.D.s representing TMA and two representatives from the Texas Hospital Association who are also M.D.s.

John H. Boyd, D.O., is the TIMA president-elect and, in addition to being a member of the Executive Committee, serves on the Program Evaluation, Finance, and Planning and Contract Committees.

Other TOMA members of the TIMA Board are Dr. David Armbruster, member of the Medical Care Evaluation Committee; Dr. Gerald Flanagan, chairman of the Appeals Procedure Committee, and Dr. Robert L. Peters, who serves on the Professional and Public Education Committee.

Consultants on a TIMA Advisory Committee include Tex Roberts, Executive Director of TOMA, and representatives of Blue Cross-Blue Shield, Texas Nurses Association, Texas Podiatry Association, Texas Nursing Home Association, Texas Dental Association, Texas Pharmaceutical Association, Texas Society of Hospital Pharmacists, Texas Psychological Association, Texas Dietetic Association, and Texas Medical Records Association.

Representing TOMA at the November meeting were Drs. Gerald P. Flanagan, John H. Boyd, Robert L. Peters and Mr. Roberts. It was again emphasized at this meeting that doctors on hospital staffs in Texas should realize that the PSRO review program, under TIMA, would be conducted in each institution by local staff members.

The TIMA Executive Committee, and staff consultants from the three component organizations, met one day and the Board and Advisory Committee met the following day to discuss in detail the many facets involved in a PSRO startup in Texas.

Among the questions covered was the relationship between Health Service Agencies (HSAs) and the proposed PSRO. Coming in for close scrutiny was the confidentiality of doctor-patient medical records and the problems of supplying statistical information (not identifiable by individuals) to HSAs. The original nine PSRO areas in Texas, designated by HEW, were dissolved in federal district court by a suit brought by TMA. There are 12 HSAs designated.

According to the proposal ready to submit to HEW, TIMA would act on behalf of the patients, the public, the practitioners and the providers to establish accountability for health care services provided under federally funded programs. TIMA would promote effective, efficient and economical delivery of such services in conformity to federal laws and regulations. PSROs have been mandated by federal legislation contained in Section 249 F of Public Law 92-603.

TIMA organizational objectives for a statewide program include:

1. Assurance of the medical necessity for health care services provided in institutions.
2. Promotion of the appropriate use of health care facilities based on individual patient needs and upon discharge planning.
3. Assurance that the quality of health care services is consistent with professional standards as applied and interpreted locally by the physician peers in the institution where the beneficiary of the service is located.

TIMA would provide central administrative support and coordination for small local review units

throughout the state, including:

1. Establishment of different review systems for acute and longterm care facilities.
   a. Incorporation of regional differences in practice patterns into the state plan.
   b. Use of existing systems for review to the greatest extent possible.
   c. Provision of methods to assure that the determination of medical necessity for, appropriateness of, and quality of medical care is made locally.
   d. Assurance that practitioner make all medical judgments while being relieved of clerical tasks.
   e. Provision of planning, staffing, and research support.
2. Maintenance and refinement of medical review within local medical referral and service areas.
   a. Definition of medical referral and service areas in consultation with local practitioners and institutions.
   b. Application of uniform statewide system of review for quality assessment.
   c. Provision of educational support and training to local personnel.
   d. Provision of consultative services to local PSRO units when indicated or requested.
3. Provision of mechanisms for impartial hearings of appeals on decisions of local review unit.
4. Collection, analysis and distribution of information and statistical data to improve the medical care delivery system.
   a. Establishment of a common data system.
   b. Provision of efficient centralized data processing.
   c. Extrapolation of information to plan continuing medical education and health resource requirements.

TIMA will provide the interface regarding these support and coordinative functions between Texas, other states, and the federal government. ^

# TOMA insurance program benefits exceed premiums

In the first year and a half that Blue Cross-Blue Shield of Texas has administered the TOMA Group Health Insurance Program, $1.25 in benefits were paid out for each $1.00 paid in premiums.

A net loss to Blue Cross-Blue Shield for the period March 1, 1975, to August 31, 1976, was $51,013. Benefits paid out totaled $255,238 against premiums paid of $204,225. Of the total benefits paid out, only approximately $29,000 was paid to physicians, while $165,000 was paid directly to hospitals under the basic coverage and an additional $61,000 was paid out under the major medical portion of the plan.

There are 177 D.O.s covered under the plan which includes low-cost group term life insurance and group health and major medical coverage. There are 1,233 individuals covered which includes 177 D.O.s, 354 employees, plus 702 dependents of D.O.s and employees.

The total number of hospital days paid by Blue Cross during the year and a half period was 1,196, with an average per day cost of $109. The total number of claims processed during the period for Blue Cross-Blue Shield and major medical was 963, at an average cost of $219 per claim.

The largest claim paid during the period was for more than $13,000. There were five claims during the period that totaled more than $47,000.

The purpose of the program is to protect the covered individuals against severe medical problems up to a limit of $250,000 for each policy. After the $100 deductible is satisfied and $500 in coinsurance is paid out in any one year, the coverage is 100 per cent. ^

# *Student Doctors teach TCOM Student Doctors*

**by James H. Brien, S/D**

The Eta Chapter of Sigma Sigma Phi at the Texas College of Osteopathic Medicine has established the tradition of delivering a series of lectures to the first and second year students in Denton. This serves the dual purpose of (1) giving some clinical correlation to their Basic Science studies and (2) it helps to bridge the gap between the students in Denton and those in Fort Worth. The lectures have been well received by both students and faculty alike.

The schedule for the Fall semester began on October 13 with a lecture on pneumonia which was presented to the Microbiology class by S/Ds J. B. Gilleland, Tommy Noonan, Mike Klett, and Fred White. On October 25, clinical correlation of anatomy of the head and neck was presented to the Anatomy class by Klett and White. November 23 Female Endocrinology will be presented to the Physiology class by J. B. Gilleland and on November 29, Male Endocrinology by Tom Halling. On December 12, clinical correlation of anatomy of the Thorax will be presented to the Anatomy class by Tommy Noonan and James Brien. A lecture on Human Sexuality is planned but no date has been set.

The co-sponsors of the Chapter are Joel Alter, D.O., General Surgeon at Fort Worth Osteopathic Hospital and Frank J. Bradley, D.O., Radiologist at Dallas Osteopathic Hospital. ^



# In Memoriam

## John E. Schwei, D.O.

John E. Schwei, D.O., of Grand Prairie died Tuesday, October 19 in Las Vegas, Nevada.

The 56-year-old family physician had practiced medicine in Texas since 1962.

A 1954 graduate of Kirksville Osteopathic College, Kirksville, Missouri, Dr. Schwei served an internship in Grand Rapids, Michigan where he had been a general practitioner before coming to Texas.

Dr. Schwei was a member of the American Osteopathic Association, the Texas Osteopathic Medical Association, and the American Geratrics Society.

Surviving are his wife, Mrs. Jean Schwei, Grand Prairie; daughters, Mrs. Jackie Fitz of San Jose, California and Mrs. Dee Taggart of Grand Prairie; granddaughters, Peggy and Sherry Taggart; and a brother, Paul H. Schwei of Temperance, Michigan.

The funeral services were held October 22 at Inglewood Baptist Church in Grand Prairie, with burial at Restland Abbey Mausoleum in Dallas. ^

# Public Health Conference in Dallas February 12, 13

The annual Public Health Conference, sponsored by the Department of Health Resources and the Texas Osteopathic Medical Association will be held at the Marriott-Dallas Saturday and Sunday, February 12 and 13, 1977.

The announcement was made by H. Eugene Brown, D.O., member of the TBHR and chairman of the conference.

He said that the Texas Society of G.P.s in Osteopathic Medicine will sponsor a seminar on Friday, February 11, at the same location.

There will be outstanding medical lecturers and speakers from the Department of Health Resources, Texas College of Osteopathic Medicine and Chicago College of Osteopathic Medicine.

The complete schedule of lecturers will be mailed sometime in January. A total of about 19 CME credit hours will be applied for, and these will be the first Class 1 CME credits available for D.O.s in the new AOA three-year period requiring 150 hours total credit. ^

# *District VI to sponsor second G.P. seminar*

TOMA District VI, based mostly in Harris County, is sponsoring its second annual seminar for general practitioners on February 26 and 27 at the Marriott West Hotel in Houston.

Ladd T. Tucek, D.O., is program chairman and says that there will be 12 to 14 Class 1A credit hours.

He says the program will cover a broad variety of topics that are especially of interest to the G.P. A general mailing will be made soon, and more information on the program will be contained in the January issue of the *Journal.* ^

# We're doing something

## *DISTRICT XIII*

When District XIII held its October meeting at the Steak Out Restaurant in Bonham, it marked the 20th anniversary of the founding of that TOMA affiliate.

Dr. and Mrs. R. D. Van Schoick of Leonard hosted the dinner and provided an anniversary cake.

Attending the meeting were Dr. and Mrs. S. E. Smith of Wolfe City, Dr. and Mrs. Roy Mathews of Bonham, Dr. David Matthews of Sherman, Dr. and Mrs. John Galewaler of Whitesboro and Dr. and Mrs. Van Schoick.

* * * *

## *DISTRICT XVI*

**by Ted C. Alexander, Jr., D.O.**

District XVI had its regular meeting on November 10 at the Wichita Falls Country club with all members present. Joe Adatto, D.O. gave an excellent lecture on child abuse.

We have had 100 per cent attendance at our meetings and we have a new member, Dr. Fred Thompson of Knox City. I also understand that Dr. Roy Fisher may have a new associate in the near future. ^

TEXAS OSTEOPATHIC MEDICAL ASSOCIATION
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Fort Worth, Texas 76107

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